



# BlueRidge Pediatrics

**Main Office**3124 Blue Ridge Road, Suite 102  
Raleigh, NC 27612  
Office Number: (919) 782-0021**Brier Creek Office**10208 Cerny Street, Suite 104  
Raleigh, NC 27617  
Office Number: (919) 226-0662

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_ Patient Phone (If 16 yrs. or older): \_\_\_\_\_

**MOTHER/LEGAL GUARDIAN**

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: (check one)

Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

**FATHER/LEGAL GUARDIAN**

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: (check one)

Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Who is the primary caregiver? Both \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_

Other (Please explain): \_\_\_\_\_

If applicable, who has primary custody? Both \_\_\_\_\_ Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_

\*(Please provide legal documentation for any alternative custody arrangements.)

**EMERGENCY CONTACT (Other Than Parent)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company Name: \_\_\_\_\_

Insured's ID Number: \_\_\_\_\_ Group Plan Number: \_\_\_\_\_

Insured (Policy Holder) First and Last Name: \_\_\_\_\_

**ADDITIONAL INFORMATION**

Race: (check one) American Indian/Alaskan Native \_\_\_ Asian \_\_\_ Black/African American \_\_\_

Native Hawaiian \_\_\_ Other Pacific Islander \_\_\_ White \_\_\_ More than 1 Race \_\_\_ Declines to Respond \_\_\_

Ethnicity: (check one) Hispanic or Latino \_\_\_ Not Hispanic or Latino \_\_\_ Declines to Respond \_\_\_

Preferred Language: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

I hereby certify that the information above is true and accurate.

X: \_\_\_\_\_ Date \_\_\_\_\_

SIGNED (Patient, or parent if under 18 years of age.)



### Initial History Questionnaire

Child's Full Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_  
Form Completed by: \_\_\_\_\_ relationship \_\_\_\_\_

Today's date: \_\_\_\_\_  
DOB: \_\_\_\_\_  
[ ] Male [ ] Female  
Chart#: \_\_\_\_\_

### SOCIAL HISTORY Please list those living in the child's home:

Name	Relationship	Birth date	Job or School	Health Problems

**Biological Parents:** [ ] Married [ ] Divorced [ ] Single [ ] Separated [ ] Remarried  
If both parents are not living together, who has custody?

	No	Yes	Comments
Are there any siblings not listed above?			
Does your child go to daycare?			where:
Does your child go to school?			where:
Does anyone in your family smoke (even outside)?			who
Does your family have any pets?			type:
Do you have smoke alarms in your house?			
Does your family routinely use seatbelts/carseats?			

### BIRTH HISTORY of your child

**Born:** on time - late – premature (how early? gestational age \_\_\_\_\_ weeks) **At what hospital?**

Birth weight: lbs ozs	No	Yes	Comments on "Yes"
Did mom have any problems with pregnancy?			type:
Was your baby born by Cesarean section?			why:
Did your baby have any problems after birth?			type:
Did baby stay in the hospital after mom went home?			why:

### PAST MEDICAL HISTORY

	No	Yes	Comments on "Yes"
Has your child had any surgery?			when :                      why:
Has your child ever been hospitalized?			when :                      why:
Does your child have any chronic or serious medical conditions?			type:
Has your child had any serious accidents or injuries?			type:
Does your child have any developmental problems?			type:
Is your child allergic to any medications?			meds:                      type reaction:
Did your child miss or skip any vaccines?			which ones:
Does your child take any medications on a regular basis?			med & dose:
Any over the counter medications on a regular basis?			med & dose:

**Where did you hear about our practice?**

\_\_\_\_\_

**Extra Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# BlueRidge Pediatrics

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Office Number: (919) 782-0021

**NEW Brier Creek Location**  
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Raleigh, North Carolina 27617  
Office Number: (919) 226-0662

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>FAMILY HISTORY</b> Any family members (parents, siblings, grandparents, aunts or uncles only) have these?							
	No	Yes	Relation/Type	Problem	No	Yes	Relation/Type
Active Smoker				High Blood-Pressure			
Allergies				High Cholesterol			
Anemia/Blood				HIV/AIDS			
Asthma				Immune Problems			
Birth Defect				Kidney disease			
Bone/Joint probs				Learning Problems			
Cancer				Liver disease			
Deafness				Lung disease			
Diabetes				Mental Illness			
Drug abuse				Rheumatic Fever			
Eye problems				Seizures			
Genetic Defect				Thyroid disease			
Heart Disease				Tuberculosis			

<b>REVIEW OF SYSTEMS</b> Has your child had any problems with or do you have concerns with any of the following:							
	No	Yes	Comments on "Yes"		No	Yes	Comments on "Yes"
Abdominal Pain				Hearing problems			
Allergy				Heart, murmurs			
Anemia				High blood pressure			
Asthma/wheezing				Illicit drug use			
Attention problems				Joint Pain/swelling			
Bedwetting/soiling				Learning problems			
Bladder/kidney probs				Liver problems			
Bleeding problems				Many ear infections			
Broken Bones				Many headaches			
Cancer/Leukemia				Many sore throats			
Cerebral Palsy				Menstrual problems			
Chickenpox				Nasal problems			
Constipation				Pneumonia			
Cystic Fibrosis				Seizures			
Dental problems				Skin problems			
Developmental probs				Sleep problems			
Diabetes				Speech/Language			
Emotional/Behavioral				Thyroid problems			
Genetic Disorders				Vision or Eyes			

**Any Other Concerns/Extra Comments:** \_\_\_\_\_

Thank you for your time filling out this form. Please sign below stating to the best of your knowledge the above information is correct.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
date

I have reviewed the above information with the parent/guardian.

\_\_\_\_\_  
Provider signature

\_\_\_\_\_  
date

## CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

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I consent to disclosure of the following protected health information about my child to the following family member(s) or person(s) involved in my child's care or payment for my child's care:

\*\*List names other than parents. If no one else should receive this information, please write "No one."\*\*

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Check all that may apply:

- All of my child's medical information
- Information necessary to schedule appointments for my child
- Lab or test results
- Information necessary to provide, call in or pick up prescriptions for my child
- Information necessary to help my child's family member(s) take care of my child
- Information necessary to allow my child's family member(s) to pick up or arrange for medical equipment to be provided for my child
- Information necessary to bill for or submit claims for care provided to my child to government or private insurance payors

My consent will remain in effect as long as my child is a patient of Blue Ridge Pediatrics, LLP unless and until I notify Blue Ridge Pediatrics, LLP in writing of any changes.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

## PATIENT BILLING AND FINANCIAL POLICY

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As a courtesy, Blue Ridge Pediatrics, LLP will file a claim for all services to your insurance. Therefore, at registration, you will be asked for your current insurance information and will be asked to sign a form verifying the information. It is your responsibility to assure we have your most current insurance information and to notify us of any changes.

It is also your responsibility as the guarantor to verify that Blue Ridge Pediatrics, LLP is a participating provider with your insurance company and to be familiar with your plan benefits (i.e. deductibles, co-payments, in and out of network costs).

To summarize, you will be responsible for a bill for the following reasons:

- The service is not a covered benefit
- Your insurance company requires you to pay deductibles
- Co-payments and/or co-insurance are required by your insurance company
- Missed Appointment/No Show Fees charged for missed appointments

For all patients who must pay their health care bills, we accept cash, check, American Express, MasterCard, Visa and Discover.

Upon receipt of a billing notice showing your balance due, you are expected to make payment in full. Please contact our office if you have any questions or need assistance with understanding your bill.

To ensure timely receipt of your account information, please contact us if there is a change to your billing address.

The parent/guardian or authorized individual that brings the child to an appointment is responsible for payment of the services rendered.

## MISSED APPOINTMENT/NO SHOW POLICY

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You may be charged a Missed Appointment/No Show Fee of \$30.00 for a missed appointment. An appointment is considered a Missed Appointment/No Show if:

- The patient is a no show/no call for a scheduled appointment.
- We do not receive a 24 hour notice for cancellation of all appointments other than a same day sick appointment.
- We do not receive a 1 hour notice for cancellation of same day sick appointments.
- The patient arrives late for an appointment and the appointment has to be rescheduled for another time.
- For any reason, the patient is not seen by the doctor at their original scheduled appointment time.

Patients who miss or no show for a double appointment (bringing two children in at the same time) will be restricted from scheduling double appointments in the future.

**ANY** and **ALL** accounts that have 2 missed appointments/no shows within the same calendar year will be terminated from the practice.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Print Name/Relationship to Patient

\_\_\_\_\_  
Date

## PATIENT ACKNOWLEDGMENT AND CONSENT

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I have been given a copy of Blue Ridge Pediatrics, LLP's Notice of Privacy Practices effective \_\_\_\_\_. I consent to the uses and disclosures of my child's health information as outlined in the notice.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

Please describe the Representative's authority to act on behalf of Patient: \_\_\_\_\_  
\_\_\_\_\_

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## MEDICAL ACCESS

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Medical History Access-Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Blue Ridge Pediatrics, LLP can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

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### FOR BLUE RIDGE PEDIATRICS' USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

\_\_\_\_\_  
\_\_\_\_\_

**Blue Ridge Pediatrics, LLP**  
**Patient Communication Information**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

In order for us to better communicate with our patients we are asking all patients to fill out this Patient Communication log.

Have you accessed our Patient Portal? **Yes** or **No** (Circle one)

If **No**, Would you like to access our Patient Portal? **Yes** or **No**

If **Yes**, Please print your **Email Address** here: \_\_\_\_\_

When we activate your email address you will receive an email confirmation from us. This will include the link to our portal, your log in and your password. If you forgot your log in and/or password the Receptionist can reset your password for you today.

Do you want to **reset** your log in and password? **Yes** or **No**

How would you like us to confirm your appointment? You can select one or both.

By Voice Mail? **Yes** or **No**

By Text (SMS) message? **Yes** or **No**

What is your preferred phone#? \_\_\_\_\_

Is this your **Home, Work or Cell Number**? (Please circle one)

What is your preferred language? **English** or **Spanish** (Please circle one)

Preferred time to call you? **Morning, Afternoon** or **Evening** (Please circle one)

Is there any special information you would like us to add to your child's account in reference to how we should contact you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient or Guardian's Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

BRP Employee's Initials: \_\_\_\_\_ Scanned: \_\_\_\_\_ Entered in ECW: \_\_\_\_\_